PUBLIC MEETING

STATE OF CALIFORNIA

HEALTH AND HUMAN SERVICES AGENCY

RURAL HEALTH POLICY COUNCIL

PASADENA CENTER

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Reported by:
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APPEARANCES

COUNCIL MEMBERS

David Carlisle, Chair
M.D., Ph.D.
Director, Office of Statewide Health Planning
and Development

Mickey Richie
Department of Health Services

Mauricio Leiva, Operations Manager
Managed Risk Medical Insurance Board

Morgan Staines, Staff Counsel
Department of Alcohol and Drug Programs

Stephen W. Mayberg
Health and Human Services Agency

Bud Lee, Chief Deputy Director
California Health Policy Council
Office of Statewide Health Planning and Development

Kerri Muraki, Rural Jobs Coordinator
California Rural Health Policy Council

Angela Smith
Office of Statewide Health Planning and Development
Health Professions Education Foundation

AUDIENCE ATTENDEES

Julie Day, Delta Dental
Mark Gamble, HASC
Raymond Hino, Tehachapi Hospital
Phyllis Murdock, Nevada Co., HSA
Phil Reinheimer, Nevada Co., A&FS
Gabe Niles, USC School of Medicine

I N D E X

P R O C E E D I N G S

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CHAIRPERSON CARLISLE: Welcome to the meeting of the Rural Health Policy Council held here in Pasadena. I'm David Carlisle, the Director of the Office of Statewide Health Planning and Development. Thank you for being here. We have a program for today's meeting. We'll be hearing some comments from Bud Lee, our Chief Deputy at OSHPD and Interim Executive Director of the RHPC and then we have a presentation by Angela Smith who is the Executive Director of the Health Professions Education Foundation on work force issues that can apply to rural regions.

I don't have too much more to add in the way of opening comments. Of course, you know, California has just transitioned through our major election process. Having been on board for only two years, this is something new that was new to me personally and I'm actually glad to have moved through it so that we can actually move forward in California government. We're still, of course, dealing with a very stressful fiscal situation in Sacramento and California in general and it's not looking like that situation will turn around anytime soon, so we anticipate a series of budget challenges into the foreseeable near term future, next several years. That's basically the situation in Sacramento.

Again, welcome to the Policy Council Meeting and I'll turn things over to Mr. Bud Lee.

INTERIM EXECUTIVE DIRECTOR LEE: Well, thank you very much, Dr. Carlisle. Welcome everybody. We have a small enough group here, we may go around and have them introduce themselves.

CHAIRPERSON CARLISLE: Sure. Sounds good.

INTERIM EXECUTIVE DIRECTOR LEE: Ray, why don't you start back there.

COUNCIL MEMBER HINO: My name's Raymond Hino. I'm the Administrator of Tehachapi Hospital, critical access hospital in California.

INTERIM EXECUTIVE DIRECTOR LEE: Phyllis.

COUNCIL MEMBER MURDOCK: I'm Phyllis Murdock, I'm the Director of the Human Services Agency for the County of Nevada.

COUNCIL MEMBER REINHEIMER: I'm Phil Reinheimer, Director, Adult and Family Services Department, Nevada County.

COUNCIL MEMBER GAMBLE: Mark Gamble, with the Hospital Council of Southern California, inland area, representing the hospitals there that are in the rural sections of Southern California.

INTERIM EXECUTIVE DIRECTOR LEE: Great.

COUNCIL MEMBER NILES: Gabe Niles, a second year

med student at the University of Southern California. I'm working with the Department of Family Medicine in developing a two-year fellowship in rural family emergency medicine.

INTERIM EXECUTIVE DIRECTOR LEE: Welcome.

COUNCIL MEMBER DAY: I'm Julie Day with Delta Dental. I coordinate the rural Health Administration Project in the helping families program for Delta.

COUNCIL MEMBER SMITH: And I'm Angela Smith. I'm an Executive Director of the California Health Professions Education Foundation.

CHAIRPERSON CARLISLE: And why don't we have the representatives on the council also introduce themselves.

COUNCIL MEMBER RICHIE: I'm Mickey Richie, I'm the intergovernmental liaison for the California Department of Health Services representing Dr. Diana Bonta. This is my 13th CSAC conference in a row. I need to announce that. You get the longevity. Oh, wait, Steve's -- Steve Mayberg.

COUNCIL MEMBER MAYBERG: I missed one. But I was wearing different hats.

COUNCIL MEMBER RICHIE: Oh, yes, that's true.

COUNCIL MEMBER MAYBERG: I'm Steve Mayberg. I'm the Director of the California Department of Mental Health and I actually predated Mickey in CSAC conferences when I used to go, wearing my county hat.

COUNCIL MEMBER MURDOCK: How many?

COUNCIL MEMBER MAYBERG: What?

COUNCIL MEMBER MURDOCK: How many, Steve?

COUNCIL MEMBER MAYBERG: How many did I go to?

COUNCIL MEMBER MURDOCK: When was your first review?

COUNCIL MEMBER MAYBERG: Well, it's got to be -- but I've missed some. But it's like 16. Something like that. I don't register anymore. I can't afford it. I'll go home tonight.

COUNCIL MEMBER LEIVA: Mauricio Leiva, I'm the Benefits Manager for the Managed Risk Medical Insurance Board. And I'm also the Rural Health Administration Project Manager for the MRMIB.

COUNCIL MEMBER STAINES: I'm Morgan Staines. I'm from the Office of Legal Services at the Department of Alcohol and Drug Programs, sitting in for my director, Kathy Jett, which folks here who see me most of the time are probably tired of hearing me say this but I'm always glad when she can't go because I always learn something here. I'm glad to be here.

COUNCIL MEMBER MURAKI: Oh, I'm Kerri Muraki. I'm the Rural Health analyst for the Rural Health Policy Council.

CHAIRPERSON CARLISLE: Great. Well, thank you, everyone. Bud?

INTERIM EXECUTIVE DIRECTOR LEE: Okay. Well, the report from the Council, first of all, I'll point out that there are a number of publications out there on the table. I want to draw your attention to the job announcement for the Rural Health Policy Council Executive Director. I've been doing this for quite some time now and I'm still, you know, interested in seeing if there is someone that would feel like taking a crack at this job.

I'm, frankly, liking it and learning a lot. I think I'm going to miss parts of this when we get somebody on board. But there is still -- I have another job, too, as a Chief Deputy with a hundred days. So we are still in a recruiting mode for that. I'd draw your attention to that.

With regard to things kind of outside of the normal things that you'd expect from a council like these public meetings, and we've got the jobs line and we have the rural grant programs and that type of thing, there have been -- there's three major initiatives that we're working on with the Council and spreading them among Kerri and myself and Kathleen who is manning the table outside, as well as a couple of other staff back at the Council. It proves to be both a challenging and exciting opportunity.

The first one that I want to talk about, in case it isn't on your radar, I do try to put out a monthly kind of a status report on projects. If you aren't on our e-mail

message list, and you'd like to be, give your card or something to Kerri so that you can be in the loop on things as they develop. You may find these next three things of interest, I would hope.

The first one really stemmed from the kind of the political challenge that erupted when the J1 visa program came into some political difficulty. And in a discussion within the Council, that included both the Departments of Mental Health and Health Services, as well as the Office of Statewide Health Planning and Development, it became clear that there needed to be some particular specialized attention paid to the difficulty that rural communities have in attracting health care work force.

There's a lot of work force gap work being done now, particularly in the nursing and physician areas. There's a whole range of other mid-level types of gaps that are very apparent also. But none of them have a focus on the rural challenges in those areas. And they are distinctly different in many respects. So, at the behest of our sister agencies, the Council took on the initiative of putting together the Rural Health Care Work Force Group. And the group has met once. It is slated to meet again in early January.

We originally started out in somewhat of a passive role, one being the Council, in its natural element, would

be to serve as a convener, a venue by which all of the respective parties could get together around a table and share ideas, best practices, make sure that we're not duplicating efforts, that kind of thing. The people that came to the table said, you know, we need a little bit more aggressive agenda because there's a lot of different places that all the stakeholders in all of this area can get together. So, they would like to be convened but also be convened with an idea of actually doing something proactive.

So, you know, we read those tea leaves and said, "Okay, if that's what you want us to do. We wanted, at the beginning, not to be so aggressive as to think that someone else's programs or agenda may be threatened. We did not want to do that. And the group that came together, I think, gave us a comfort level of basically a go-ahead to there is no other organization serving this purpose and therefore if you stay on that purpose, you know, you'll be fine. You won't be generating any kind of push back from other organizations who may be involved in a similar thing, but not the same. So that's our niche is to try to find and maximize the resources that can be gained through collaboration and getting together and sharing ideas and information and best practices and all those kinds of things.

The group had a full day meeting and thanks to the

California endowment, who shared some very nice space for us to use and get people together. And they fed us, too. It was real nice. We developed a kind of -- we call it a 50,000 foot agenda. I mean, it's still forming up. There was a lot of willingness to share with each other what has been done in the past.

We first of all wanted to figure out, you know, where are we. In order to know where we are, we need to know where we have been. And in particular there may be some situations in the "where we have been" category that had good ideas but sometimes they're just not at the right time, that may have more timeliness now. So we wanted to dust those off.

So there's a rather intensive sharing of information that is going about and among the parties that are in this group. And we intend to come back with a -- in January, with a more well-developed agenda that is going to be multi-dimensional nature. The basic structure is going to be with a time orientation; that is, what is it that we can do in the relatively near term. And we're talking there a year or two. I mean, it's not like six months. But what can we do in the relative near term and then what can we do long range so that we don't wind up being in the position that we're in now, for example, with the nursing shortage or the mid-level or other allied health professional gaps that

are growing. We need to figure out a way on a long-term basis to try and close those gaps.

So it's really a time orientation to the agenda and then it will also be separated out into after problem identification, what is the venue for problem addressing. Is it administrative? Is it legislative? Is it local? Does it have to be a statewide solution? Those kind of sorting out processes. Actually it's going to be exciting. I'm looking forward to that.

I'll give you just an example of the thing that actually we're working on in the Council right now. We've parceled a lot of the assignments out to members of the group. If you come, you've got to be willing to share and work in between the meetings. But as an example, mid-level practitioners, a huge political issue just off the top of your head, if you've been around Sacramento in the political environment for a while. But there are -- so, those debates will take place in terms of whether or not there should be some testing of additional mid-level practitioner buildup, say, like, in the oral health field or in the mental health field or, you know, other kinds of areas.

But immediate thing that we think would be very helpful, we were asked to do, is to array all of the mid-level practitioners that we know of in terms of their different licensing structures, the academic requirements,

the licensure requirements, of particular interest for people who are working in institutions in rural communities. It gets down to the basics of knowing who can supervise who. You know, just so that you don't wind up getting in trouble by having someone supervise someone else but they're not technically or legally qualified to do so. So we're shooting for a product along that line in early January, at least the beginnings of one.

So there's some near term things that we can try to do and then there's some longer range things. I will keep you abreast of what's going on via, I hope, for monthly updates. I'm not sure if I'm going to make October yet but we'll give it our best shot.

Okay. That's the Rural Health Care Work Force Group. It is a group that is kind of forming up. It's got about 20 or so folks in it. Some people can, you know, make different meetings. I think we've got a pretty good span of representation. From the county perspective, CHEAC is involved. They couldn't make the first meeting but they are well aware and will be involved in this in the future. County Health Executives Association of California.

So that's the first major kind of initiative that was launched at the request of people who saw a need and thought that the Council would be the best organization to kind of fill that need. So stay tuned on that one. We're

looking forward to great things from that.

The second one is one that is a little lower profile but it's still very high in the minds of the rural health care provider community and that has to do with managed health care, HMOs, you know, geographic access; for those of you who aren't familiar, there is a what is referred to as -- it's a little confusing to me, sometimes, both an access standard and a guideline of HMOs using local providers if they are within 15 minutes or 30 miles of someone's either domicile or work location. It's a guideline that is difficult, at best, to enforce. It's largely been unenforceable.

We've had a number of conversations raised in and on some of these with the Department of Managed Health Care. Actually, it's taken on a new tack. We're not quite sure how it's going to play out yet but there was legislation last year which basically eliminated that access standard and told the Department of Managed Health Care, "Go back to the drawing board. Figure out something that can work and promulgate regulations to, you know, make something out there that's enforceable."

I had a conference call just last week or so with the Department of Managed Health Care. So, how's it going? They're struggling with it. They're looking for input. I think it was the rural provider situation in kind of a macro

sense. It was not fully on the Department of Managed Health Care's agenda. They had a lot of other stuff on their agenda and their newness since they have been born but this is an issue that predates them way back when the Department of Corporations, was -- had oversight over Knox-Keene Act.

The outcome of the last conference call was basically that the Department of Managed Health Care will be convening a meeting that will include all of the affected stakeholders, including the rural health provider community. Somehow some representation from consumers on the health plans themselves and anybody else who kind of fits into that area that they would be affected by it.

There hasn't, to my knowledge, ever been a convening of a group like that, specifically to address geographic access standards. To be frank, the difficulty that the Department of Managed Health Care is having, and I'm somewhat sympathetic to them on this, is that the law that was recently passed is very narrowly focused upon the geographic access standard. That standard isn't a problem in and of itself. It's a derivative of a lot of other situations that make it a problem; most notably, I think, the financial impact on the rural provider community when the standard isn't adhered to.

So there are very substantive -- I hesitate to call them ancillary issues, they're almost central -- but

according to the law that was passed, they're kind of ancillary. So we've got to figure out a way to help the Department of Managed Health Care work through that issue. I think the opportunity to have input, in a formal process, for them to develop new regulations is more of an opportunity than a setback for us.

So that's where we are with the Department of Managed Health Care geographic access standard/guideline. We're going to have to clean our language up. We're going to have to have one or the other. And I'd appreciate it if during the public comments, if Ray or Mark or anybody wanted, you know, to give us some feedback on what provider community may be thinking about that.

Last, but certainly not least, is the report to the Legislature that is currently going through its iteration from a rather extensive annotated outline to an actual narrative, still with some holes in it. Kerri, bless her heart, is helping me through that.

This is a report that was mandated by last year's budget act. And the intent here was to try and put into the public record via a public agency process, not a special interest group. I have a record of what is the situation with regard to rural health care in California, and they ticked off a number of things that the Legislature wanted us to address and that's what we're doing. Again, with the

input of a rather large task force that we convened over long conference calls and we're scheduling another one for next week, and we've had one meeting and a pretty long conference call. We'll get it winnowed down into something that I think that the most meaningful parts of these are going to be, of this report, will be two.

One of which would be to establish the need for some programs that help rural communities and there is no question about whether or not they are helpful or not. They may be at this time not fundable because of the General Fund condition. But let's put the record of those programs in the public record as to their merit so that if the General Fund condition comes back into a position where it can be -- re-generate some funding, say, like, for the capital grants program, which is all general fund, there won't have to be a debate about whether or not that program is any good. That's already in the record and it's done by a public agency, not someone who has a particular agenda to advance.

The second part of that report that I think is going to be most interesting and helpful will be for us to go through the issue identification process for rural -- in rural communities to try to sort them out into if there is an issue, what is its remedy and where does it lie? Is it a local kind of an issue? Is it an administrative remedy, say, like, at the state level where we can either adjust

some practices or regulations or is it something that is needed to be addressed via the legislative process? And we just want to try to lay those out as options so that we know if we try to shoot for addressing some problems there might be some that could be taken care of a little more easily than others. For those of you who are familiar with the legislative process, that's probably the most challenging. So if we can do something short of that that meets some needs then that's the direction that we'd like to go.

So those are the three major initiatives underway at the Council that's keeping us very busy. You know, it's a great -- those are great things to be working on and we enjoy them and look forward to any support that we can get from you. That's my report.

CHAIRPERSON CARLISLE: Well, thank you very much. Why don't we now just take a moment and if you have questions for Bud Lee, go ahead and address them. Yes?

COUNCIL MEMBER DAY: I have one under the rural --

INTERIM EXECUTIVE DIRECTOR LEE: Speak up real loud or maybe turn the mike over to her or something.

COUNCIL MEMBER DAY: I can talk real loud. Rural health care -- pardon me?

INTERIM EXECUTIVE DIRECTOR LEE: Could you identify yourself, please.

COUNCIL MEMBER DAY: Julie Day with Delta Dental.

On the Rural Health Care Work Force Group, do you take suggestions or do you take new members or --

INTERIM EXECUTIVE DIRECTOR LEE: Well, we're -- suggestions for sure. We are having -- as you might imagine, there's a lot of people that are interested in this. And we're having to make sure that we have good representation from the various groups. If there's a kind of a particular -- I don't know where Delta Dental might fit in --

COUNCIL MEMBER DAY: Rural health.

INTERIM EXECUTIVE DIRECTOR LEE: Yeah, we have the Rural Health Initiative. I'm not sure if you're familiar with that, but if it's suggestions, I would --

COUNCIL MEMBER DAY: What the mechanism would be to feed --

INTERIM EXECUTIVE DIRECTOR LEE: Yes.

COUNCIL MEMBER DAY: -- projects to you that --

INTERIM EXECUTIVE DIRECTOR LEE: Yes.

COUNCIL MEMBER DAY: -- obviously are directed towards the rural health.

INTERIM EXECUTIVE DIRECTOR LEE: Yes. That would be your -- that would be your best bet.

COUNCIL MEMBER DAY: Okay. Thank you.

COUNCIL MEMBER MICKEY RICHIE: Bud, do you anticipate that when the report to the Legislature is

finished that sub 3 will want a hearing on it?

INTERIM EXECUTIVE DIRECTOR LEE: Probably. I mean, I wouldn't rule it out. Although I -- you know, I think that the report itself is going to be pretty kind of descriptive. It's going to be describing the current status and to the degree it has anything to kind of chew on by the Legislature, it would probably be in that -- in those areas that have been identified as issues that can only be resolved legislatively. So I'm guessing that that may be of some interest to them. But other than that, I'm not sure.

COUNCIL MEMBER MICKEY RICHIE: I guess I was wondering what's the number of new members coming in that it might be an opportunity to pull some of the rural members in and give them a snapshot and update, a little orientation.

INTERIM EXECUTIVE DIRECTOR LEE: That's a good idea. Good.

CHAIRPERSON CARLISLE: Other questions? Yes.

COUNCIL MEMBER HINO: Just a comment. My name is Raymond Hino. I'm the Administrator of the Tehachapi Hospital and we're a 24-bed critical access hospital in southeastern Kern County. We have so many challenges ahead of us that I could probably spend a lot of time but I'll try and make my comments brief.

Among the challenges that are facing us, of course, there is SB 1953. We're a member of the Rural

Health Design Consortium and actually have been identified as the pilot project for the Rural Health Design Consortium so we're looking forward to initiating a feasibility study in our community, hopefully with some grant funding to look at replacement of our hospital facility through that mechanism.

Health manpower shortgage, of course, is an issue for us. Medi-Cal funding inadequacy is a huge, huge issue for us in that our -- we -- our Medi-Cal reimbursement is somewhere in the neighborhood of 10 cents on the dollar for what we charge out for our services. But as Bud said in his opening comments, managed care access in rural communities is one of the biggest issues that we face and if I could add a little bit of fleshing out of some of the issues that Bud is talking about.

First of all, we appreciate the leadship of Rural that he's taken with respect to this issue. Bud has convened several meetings, either telephone conference meetings or meeting with the Rural Health -- the California Health Care Association's Rural Health Board on several occasions to detail the problem.

Our small hospital is impacted by at least three private managed care plans. We also have two Medi-Cal managed care plans in our community. Our problem is not so much with the Medi-Cal managed care plans in our area as the

private plans. Of the three private plans serving our area, all of them routinely disregard the 15 minute, 30 mile or 15 mile, 30 minute regulation that Bud was talking about, although people are members or beneficiaries of health plans in our area, the plans, themselves, routinely refer those individuals outside our local community to the larger communities in Kern County and Bakersfield, in particular.

When that -- every time that happens, it hurts the financial feasibility of our hospital for services that we can provide. We're aware of women that are foregoing their mammograms because their health plan requires that they drive 50 miles to go to Bakersfield. We're aware of employees that needed physical therapy that were sent 50 miles away to Bakersfield for that service. And we're aware of patients that have requested to be admitted to our hospital for their inpatient admission and they are referred 50 miles away to Bakersfield.

And it seems to not matter whether we have a contract or not. In one case we have a contract and all of that, all of those patient referrals continue to go to Bakersfield. There are two other plans that refuse -- one that refuses to contract with us and refers all of their patients to Bakersfield. One that we recently discontinued a contract with because the payment was so inadequate. And they were referring the patients to Bakersfield, anyway.

It's a very huge issue as far as the financial viability of our facility.

We have had some dialogue with the Department of Managed Health Care. There was an advisory committee meeting that was held two weeks ago. The advisory committee received testimony from hospitals and from hospital counsel as well. I testified at that meeting. I'm encouraged by the fact that representatives of the Department of Managed Health Care indicated that they were not aware of the issues of the financial viability of rural facilities as the new regulations may impact them, and are very open to dialogging with our facilities and with our organizations to help come up with better solutions.

CHAIRPERSON CARLISLE: Good. Other questions or comments for Bud? Okay. Well, thank you very much. Thank you, Bud.

We'll now move to item number II on the agenda. I'd again like to introduce Angela Smith who will be giving us a presentation on the Health Professions Education Foundation, particularly about scholarship and loan repayment opportunities for individuals pursuing health care careers. Angela.

COUNCIL MEMBER SMITH: Good afternoon, everyone. As Dr. Carlisle mentioned, I am with the Health Professions Education Foundation. We work very closely and receive

administrative services from OSHPD. I'm not sure how many of you are aware of the foundation. I did bring some handouts of the presentation that I'll be giving today, if you got those.

I'll just start off by letting you know that the Health Professions Education Foundation is a nonprofit public benefit corporation established for the purpose of providing health professionals to medically under-served areas within California. And it was established to also increase the number of demographically under-represented and economically disadvantaged students that are practicing health occupations.

It was established through legislation that was written by Senator Watson in 1987. The foundation makes scholarship and loan repayment grants statewide through two funds:

One, the first is the Health Professions Education Fund which is funded through grants from public and private agencies, contributions from foundations, corporations and individuals. You may be interested in who some of our contributors have been thus far and they -- foundation contributions have come from the California Endowment, the California Wellness Foundation, the San Francisco Foundation. We've also received support from Irvine Medical Center and we receive contributions as well through the

United Way and other direct mail campaigns that we administer through our office.

This -- the Health Professions Fund, I should also mention, is in the midst of a ten million dollar campaign that started in 1999 and will -- has just about two years left. It will end in 2004. But we have achieved about 7.4 million dollars thus far in commitments.

The next fund that the foundation administers is the Registered Nurse Education Fund which, actually, that fund was established in 1988 by then Senator Ken Maddy and the purpose of that fund was also to help California at that time deal with the nursing shortage and also to increase the number of underrepresented nurses that were practicing in California. This fund annually collects over $600,000 and we award scholarships to Associate Degree nursing students and also Baccalaureate of Science degree nursing students in that fund.

These are seven of the foundation's programs and there is now an eighth program. As you can see, the first three bullets support -- are supported by the Registered Nurse Education Fund and that's the Associate Degree nursing scholarship program, the BSN scholarship program and the Nurse Loan Repayment Program.

The thing about the Registered Nurse Education Fund is that it only supports Associate Baccalaureate degree

nursing students and I should go further by saying that the fund only supports -- 5 percent of the fund is actually used to support ADN students and the other 95 percent is for BSN students in the form of scholarship and loan repayment.

The Health Professions Fund, which is the fund that is supported through foundations and corporate contributions and such supports the latter four programs which are the Kaiser Permanente Allied Health Care Scholarship Program and I should have mentioned earlier that Kaiser has been a great supoprter of our foundation since 1994 when that particular program was established.

The Health Professions Scholarship and Health Professions Loan Repayment Program, the Youth for Adolescent Pregnancy Prevention Leadership Recognition Program, which is a program that is funded by the California Wellness Foundation, that was a new program that we added this year and it really targets youth age 16 to 24 that are helping communities throughout California reduce rates of teen pregnancy. So that's a really unique program where we're kind of reaching down to those youth who are helping to do positive things in their community around the issue of teen pregnancy prevention.

COUNCIL MEMBER RICHIE: Angela, on the Youth for Adolescent Pregnancy Prevention, is that in order to try to move those people into health professions or are -- I'm not

seeing the link between --

COUNCIL MEMBER SMITH: Yes.

COUNCIL MEMBER RICHIE: -- health professions and that. At least the title is throwing me off.

COUNCIL MEMBER SMITH: Yes, it is. Basically, these students are working in more of a public health capacity at this point. But we are -- they are -- have a desire to pursue health professional careers and so through the application process that's verified and they are enrolled in actual health occupation programs. And so that is who the program targets. They are actually health students.

And then the last program that was recently implemented in July this year was the Central Valley Nursing Scholarship Program, which is a program that is funded by the California Endowment. It's a $1.9 million program funded over three years and it's a regionally specific program focused in the Central Valley, six-county area of the Central Valley.

We just wrapped up the first application cycle for that program and should be announcing about $240,000 in awards at the end of this month so that's something that we're really excited about.

I've kind of mentioned already who the scholarship programs target but just for a quick review: ADN and BSN

students, we target Allied Health Professionals, Medical Imaging and Occupational Therapy, Pharmacy and Pharmacy Techs, Physical Therapists, Respiratory Care, Social Work, et cetera. And then we have loan repayment programs that target BSN or Baccalaureate Degree nursing graduates, nursing and delivery graduates, Nurse Practitioner, PA, dentists and dental hygiene graduates.

What are some of the eligibility requirements for the foundation's programs? We have a written application process. Each applicant must submit an official transcript, two to three letters of recommendation. Generally our applications have about six questions that are really kind of zeroing in on the applicant's health-related work experience, their community involvement, their community background and upbringing, their career goals. And also do they have financial need. Because again, we get more applicants, obviously, than we can fund. Those are the primary criteria that we use to screen applicants and any applicant who receives a score of 70 percent or above could be awarded a scholarship or loan repayment grant from our office.

This is kind of hard to see but at a glance basically what the chart says is that the foundation since the inception of the BSN and loan repayment programs in fiscal year '90-'91 through this last fiscal year, had

awarded over $6.7 million in nursing and allied health care scholarship and loan repayments to nearly 1400 students statewide.

This kind of breaks it down because there's been a large emphasis on California's nursing shortage. We're often asked about the contributions from the nurse surcharge renewal, and again, through the 2000-2001 fiscal year, the foundation had provided $5.9 million in RN scholarships. So you can see that in the early years of the foundation's operations and really until '98-'99 when we started the fundraising campaign for the health professions fund, that the majority of the funding was coming from the support that nurses in California give the foundation.

This kind of just breaks out the awards by program, kind of showing how the foundation monies have been allocated and who they support. Same with monies from the Registered Nurse Education Fund, you can see that the majority of the support has gone to support BSN students and then next would be BSN graduates through the loan repayment program which is there shown as LRP.

The scholarship and loan repayment applicants versus awards by ethnicity, you recall that when the foundation was established in 1987 by Senator Watson it was established to address really two things:

One, the shortage of health professionals

practicing in under-served areas of this state and also to address the lack of representation amongst underrepresented groups in the health profession.

And some of you may be familiar with the fact that the foundation used to be called the Minority Health Professions Education Foundation. But the foundation has always supported members of all ethnic groups and that was somewhat a misnomer and often caused a lot of confusion about -- from people who were not members of underrepresented groups.

So in year 2000, Senator Martha Escutia sponsored SB 308 and we did formally change the name of the foundation along with some other things.

This kind of shows you how the programs have done so far in terms of outcomes, with the awards that we've made, who have actually completed the program. The Associate Degree Nursing Scholarship Program, I should have mentioned earlier, was -- it started off being an articulation program, to see whether it was possible for Associate Degree nursing students to articulate from an ADN to a BSN program. And it's no longer a pilot program but this program, as you can see, there's been 10 students since we implemented this program in 1994 who have actually successfully completed the pilot.

A number of students are still enrolled in the

Associate Degree nursing programs, some have graduated but still have not completed their BSN degree so that's where you see the 36 students. And then you might think that there's a high number of students who have actually breached their contract. If you look further into the breaches, when we break it down, you see that 17 percent of the students who have breached this particular program breach because they just didn't complete their Associate Degree nursing program.

This percentage is actually a little bit better than what you see in other community college attrition rates. I think they are a little -- they are over 20 percent of -- I don't remember the exact percentage, but I know they are somewhere about 22, 23 percent. So we're doing a little bit better in that regard.

Then the other portion of our breaches is related to the fact that the students, while they completed their Associate Degree in nursing, they have not completed their BSN degree, which is a requirement and a stipulation of receiving these funds. They have to do that within five years. And then for some reasons, peoples' obligations was waived, medical reasons -- you can basically see the reasons there.

COUNCIL MEMBER MICKEY RICHIE: What's the 31 percent?

COUNCIL MEMBER SMITH: They're -- it's active. They are actively enrolled in a nursing program. I'm sorry. That did get cut off.

COUNCIL MEMBER GAMBLE: Can I ask a question?

COUNCIL MEMBER SMITH: Sure.

COUNCIL MEMBER GAMBLE: Is something being done to address the attribution rate in the junior colleges -- or in the community college level?

COUNCIL MEMBER SMITH: Well --

COUNCIL MEMBER GAMBLE: I mean, is there something that this program can do to address that more specifically?

COUNCIL MEMBER SMITH: I think from a public policy perspective, I know that Senator Thompson or -- I'm sorry, it's Assemblymember Thompson, I think AB1140 established a specific goal of trying to get the state universities to work with the community colleges and develop some articulation agreements because a lot of the problem is that the prerequisite courses aren't necessarily transferrable between systems. And so they need to establish articulation agreements. So that would definitely help the problem. Does that answer it?

COUNCIL MEMBER GAMBLE: Somewhat, but I -- just I would hope that there are other ways that we could support the students that do get into these programs and some of them may not have the training before they get there to

really -- nor the discipline, to work through these science programs. And is there some tutoring or some mentoring that could be --

COUNCIL MEMBER SMITH: Yeah, math and yet you're right. Some of the high attrition rates are attributed to the fact -- there was a report done in 2000. There was a convening of Associate Degree nursing program directors and BSN program directors and they identified some of the barriers for recruitment and some of the barriers for completing the ADN programs which are very much what you highlighted.

The students, one, are selected through a lottery system and some of them are not well prepared in the math and science background. And then there's not a lot of resources or support for tutorial services and mentorships that would help these students be successful.

And I also know that about 60 percent of community college students in these Associate Degree nursing programs work to finance their education, to support family, and so that also impacts their ability to be successful in these Associate Degree nursing programs. So I know that there are various public policy things that are occurring to try and address some of those issues.

But some of it is just -- it's resource-based. It's based on finances and the programs are, you know,

crying to try and get more budget dollars so that they can address some of those issues. It's well documented but the resources aren't there, is what I'm hearing.

COUNCIL MEMBER GAMBLE: Maybe through the foundation you can do something to address those issues for those students coming in specifically to this program with helping with the resources and the tutoring and the mentoring. The hospitals in Ventura County have a program in Moorpark College where they are actually staffing tutors to help the students get through the program and so they don't have the -- they have a better retention rate and a better pass-fail rate and they are not losing the students halfway through because that's a significant cost.

One, they take up a seat in the classroom and keep somebody who may work through that program, from graduating, from getting in, and so it has a double-sided result, which is kind of a double negative.

COUNCIL MEMBER SMITH: Right, right.

COUNCIL MEMBER GAMBLE: So, I think that is -- we'd like to see something done to help those students that want to pursue a career, get through the sciences.

COUNCIL MEMBER SMITH: Get through the sciences.

COUNCIL MEMBER GAMBLE: Okay. Thank you.

COUNCIL MEMBER SMITH: You're welcome. Okay.

The next is the Registered Nurse Education

Scholarship Program and the outcomes for that. We've made about five hundred and ninety-seven awards for that particular program. The breach rate is a little better. It's about 20 percent; again, 10 percent of those have breached the program and the other 9 percent have breached because they didn't complete their obligation to work in an under-served area of California for two years.

The loan repayment program actually gives the foundation the best in terms of program outcomes and I think that's pretty consistent with financial resources that are available across the U.S. Loan repayment programs tend to do better because the students have already completed their education requirements. So this particular program, the breach rate is 7 percent.

The Allied Health Care Scholarship Program, this onen is also a little bit unique because the students either have to work in an under-served area of California or they can also volunteer in an under-served area of California. And we might note that this is funded through Kaiser's community benefits program. So these -- often these -- the recipients of these scholarships do not work at Kaiser.

These are some of the counties or these are the counties that have been served by the foundation's recipients through 2000, 2001. I believe there's 49 of 58 California counties here. We did add two additionals.

We'll be, by the way, coming out with a new annual report in January so if any of you would like to receive a copy of our annual report you can also give me your business card.

Just a listing of our Board of Trustees. I should probably mention that one of our Board members was recently elected to the State Assembly, Kevin McCarthy, in Bakersfield. So we will be getting a replacement for Kevin. And we also have several new appointees to our Board. Some of you might be familiar with some of those.

And our contact information. This contact information is different from what you have in your handout. The handout still had our old address and I do apologize for that. But this is the correct information. As well I have business cards while I'm here.

If there's any other questions, I'd be happy to entertain those.

CHAIRPERSON CARLISLE: Anything else for Angela?

COUNCIL MEMBER RICHIE: I was just going to ask Angela, why there were 14 -- with registered nurse education enrollment program outcome, 97 are currently practicing in medically under-served areas, 127 recipients have completed -- I'm assuming that the difference between the two, have served and have moved on to an area that doesn't have that designation?

COUNCIL MEMBER SMITH: No, actually, some of

these, they don't add up because some of the awardees have received loan repayment more than once. I should have stated that. They can receive up to $19,000. Generally they receive $8,000 over a two-year period so they have to re-do an application process. And so that's why the numbers don't actually add up.

COUNCIL MEMBER RICHIE: Okay. Thank you.

CHAIRPERSON CARLISLE: Other questions for Angela?

COUNCIL MEMBER STAINES: Yeah, I have one. May I?

CHAIRPERSON CARLISLE: Yes.

COUNCIL MEMBER STAINES: Can you tell us a little bit about -- particularly I've just thought about the county, the medically under-served counties, and so the -- the one that we never talk about here is San Francisco. And I'm just curious how -- what the range of medically under-served includes. How you look at that.

COUNCIL MEMBER SMITH: Well, I guess I should've mentioned that all county health facilities qualify for the foundation's programs and are designated as shortage area practice sites. So anyone who applies and is working for a county health facility. And so to answer your question, a lot of the people practicing in San Francisco County are at San Francisco General, they're at the jails, the San Francisco jails. They're in the Mission Neighborhood Health Center in San Francisco. Just to give you an idea.

CHAIRPERSON CARLISLE: Okay, Angela, thank you very much.

COUNCIL MEMBER SMITH: You're welcome.

CHAIRPERSON CARLISLE: Well, I think we've at this point reached the conclusion of the more structured part of the agenda for the Rural Health Policy Council. And I think we'll move on now to the Public Comment period.

And while the Council Members are here now to receive commentary and questions from members of the audience. And if you have questions, I think we have a fairly -- obviously a small number of attendees, we can have a fairly informal session here today. We don't have to submit written questions or anything like that. But go ahead and lead the way, whoever wants to submit anything to us.

MR. GAMBLE: Mark Gamble, with the Hospital Council of Southern California. In addition to echoing what Ray has said about the Managed Care claims, he also mentioned SB 1953 and work force issues.

In particular, now, the hot topic, now that the comment period is open, is the nurse staffing ratios and you know all the specifics, I'm sure you've all heard it over and over again, but just to emphasize it again that it's going to be -- it's an onerous mandate on the hospitals in suburban areas. Hospitals around us are going to have a

hard time filling those ratios. It's going to be an even broader and bigger impact on the rural hospitals.

And there were not the exceptions built into the laws as it was finalized to give the rural hospitals any kind of leeway on that. They do have to file -- I guess you have to write in a letter of flexibility requests but that's not very clear and I don't think that's very broad at all. And they're already having a hard time recruiting nurses in all the other positions to go out there and then what is going to happen if they cannot meet these mandates. And what's going to happen with the Department of Health Services. I know the onus is going to be on them to enforce this. And it's going to be a challenge and it's just an additional challenge, but it's already -- it needs -- it's exacerbating the problem, it's not doing anything really to address a solution to a problem. So that's, I guess, the biggest issue that we're facing right now from a work force or manpower issue.

The other Ray mentioned is SB 1953 and the seismic mandate. I'd like to take that in somewhat of a different direction and that's the current situation with OSHPD and the lack of staff. And I know hands are tied there, as well, but a hospital in my area, out in Riverside, rural hospital, started a women's center construction about two, two and a half years ago, and I just -- I think they may

have just received final approval or still not received final approval.

There's been issues with the OSHPD inspection and fire marshall and there have been delays that have been caused and it caused the project to go over budget and this is a rural hospital that was using a lot of foundation money and grant money and they weren't able to get any more funding, so they had to instead of buy the equipment, which was over the original budget, they had to go out and lease equipment and furniture.

And that is going to add an expense over a longer period of time and it's been frustrating, I know, for the hospital CEO. And to piggyback onto that, now, we've had significant growth out in the inland area and there are hospitals not only looking to meet seismic compliance but also to expand emergency department capacity and inpatient capacity and we need the beds now and the emergency capacity now, but with the planning and the time frame that it is going to take, it's two, three, four, five years before we'll see any of this increased capacity.

And then with the SB 1953 mandates and all the process that that's going to take, it's another challenge that we're all going to have to face and again, it is not fixing a problem. It's almost making a problem that's already there worse. And so I guess it's more instead of

asking you what you can do, I'm just telling you that there are a lot of frustrated hospital administrators out there.

CHAIRPERSON CARLISLE: Mickey, did you want to comment on --

COUNCIL MEMBER RICHIE: Oh, on the nurse staffing ratios, no, not really, except Mark, you said that something was fuzzy that needed clarification?

MR. GAMBLE: Well, I don't know if it's fuzzy is the right word, but I think the rural hospitals in terms of any kind of flexibility, really, there wasn't much flexibility written into the law, is my understanding, for the rural hospitals. And Ray, can you clarify that for me if I'm not being clear? But I think they -- the only -- you have to submit a letter of flexibility, or a request for flexibility, when you aren't able to meet the requirements.

COUNCIL ATTENDEE HINO: I think you're right, Mark.

MR. GAMBLE: And --

COUNCIL MEMBER RICHIE: But just what that really means hasn't been defined yet, you're saying?

MR. GAMBLE: Well, it has, but it's, I think it's -- I think it's on a per occurrence basis. So if a hospital can't meet the -- if a rural hospital can't fill a position -- let me go back and check with Sharon Avery on this --

COUNCIL MEMBER RICHIE: Okay. Okay.

MR. GAMBLE: -- and get back to you. But I know there are some specific concerns for the rural providers.

INTERIM EXECUTIVE DIRECTOR LEE: I've had some dialogue on both sides for the hospitals, as well as with Licensing and Certification. And the feedback that I've heard from the Department of Health Services, and Ray, you may be able to help me here a little bit, is that I think it's their view, and I don't want to speak for them, so Mickey, this is kind of what I think I've seen, is, because of the nature of rural hospitals with their relatively smaller population of patients, that I think it's their view that it's not going to be difficult for rural hospitals to meet the nursing requirements, assuming that they have a nurse, you know.

If you have a nurse, just because of the patient volume, because many of the volumes and the ratios, the numbers in the ratios are probably less than the number of patients that you would have in the hospital. So I think my sense is you -- my experience with DHS licensing is they have always been responsive as they can be within the kind of legal constraints that they have. But I don't think they're -- I don't think there's any resistance there.

But what I'm kind of hearing is that they don't quite understand really what is the problem with rural

hospitals compliance within their staffing ratios. They don't understand that.

COUNCIL ATTENDEE HINO: There's several unanswered questions from what I understand. I heard a laundry list about a week ago. One of them, that comes to mind, was the question of what happens mid-shift if another patient's admitted which then throws the hospital out of compliance with its staffing ratio. What happens then.

I tend to agree with what Bud is saying in that in our particular hospital situation our percentage of patient days are fairly low, which makes it a little bit easier for us to meet the staffing ratios. What we're concerned about actually, how we anticipate it's going to affect us, we transfer a lot of patients out for tertiary care and a higher level of care. And right now we have a great difficulty transferring patients out because of shortage of beds in the areas that we transfer to.

And what we're hearing is that the shortage of beds is going to grow with the implementation of the nurse staffing ratios. As we understand it, what will likely happen is that more beds will be closed because hospitals are out of compliance with their number of nurses on the floor.

INTERIM EXECUTIVE DIRECTOR LEE: Okay. Those cover a specific kind of thing we can follow up on.

COUNCIL MEMBER GAMBLE: And that also leads to a point that there are the seasonal rural hospitals and there's one up in Big Bear that you can ski right into their emergency department and exit. You're probably -- if you're going to end up in it, you're not going to ski down. But they are there at the bottom of the ski slopes. And I know they will have -- I think that's where the challenge for some of the rural hospitals are going to be, where they're seasonal, and they're going to have to adjust their staffing and, you know, maybe they can attract some of the staff up there to take advantage of the seasonal opportunities.

But then the feedback on what Ray said with the capacity issue, is that same hospital had a patient that it needed to transfer to a higher level of care, called 42 different facilities throughout Southern California before they could find a hospital that would accept him. So, that's, that's the capacity issue. That is also going to be exacerbated, as Ray said.

CHAIRPERSON CARLISLE: Speaking to the issue that you identified with regard to hospital construction or the issues, I'd like to invite you to follow up with me in detail about the hospital that you mentioned in Riverside.

COUNCIL ATTENDEE GAMBLE: Okay.

CHAIRPERSON CARLISLE: To make sure that everything flowed the way it should in that situation. An

aggregate, the office -- we recognize the issues of course that you mentioned in terms of potential throughput, about delays, et cetera, et cetera, we've been so far performing at about a rate comparable to where we've been historically. And that may even be an improvement over where we were some years ago in terms of efficiency.

But we recognize that the hiring freeze may actually impact our ability to maintain that degree of efficiency. And it's a major challenge for us. It's always a challenge, actually, to bring in engineers into civil service. Recognizing that, however, I think the office has been relatively successful in receiving freeze exemptions for the facilities development division to bring in people to address those personnel issues and so we have received several exemptions for engineers in that division.

I think that the process is cognizant of the importance of continuing the successful review of hospital building plans, especially under the 1953 requirements.

MR. GAMBLE: Okay. I know your hands have been tied in this. It is appreciated, the efforts that your staff do put in at the field level.

CHAIRPERSON CARLISLE: Thank you. Yes, and all those of you who are representing or have contacts in the hospital industry should know that there is an extension request mechanism that the hospitals can utilize to receive

up to a five-year delay in the 2008 structural performance deadline. And hospitals should check with the office if they have an interest in that extension process.

Comments? Other comments or questions for the Council? Any questions or comments from the members of the Council?

Well, I think we have reached the end of the meeting then. Again, Angela, thank you for your presentation. Thank you all for being here. If you have particular questions that you do want to check in with us on, in more detail, we're available after the meeting. You certainly can visit the office's website. The Policy Council's website and the websites of the other departments, too, for access to individuals or information.

Again, thank you very much for being here.

(Thereupon, the meeting of the California Rural Health Policy Council was concluded at 2:41 p.m.)

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CERTIFICATE OF REPORTER

I, PETER PETTY, an Electronic Reporter, do hereby certify:

That I am a disinterested person herein; that the foregoing California Rural Health Policy Council Meeting was reported by me and thereafter transcribed into typewriting.

I further certify that I am not of counsel or attorney for any of the parties in this matter, nor in any way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 23rd day of December, 2002.

Peter Petty

Official Reporter